

Cognitive behaviour therapy with compulsive hoarding: a single case study

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Abstract

The current case study used cognitive behaviour treatment (CBT) for the management of a 35-year-old, married man who presented with complaint of compulsive hoarding. The complaint of compulsive hoarding (excessive acquisition, difficulty in discarding saved material and cluttering) was accompanied by feeling of anger, sad mood, low confidence, decreased sleep and appetite, poor problem solving ability, indecisiveness and interpersonal conflicts. The study was approved by the institutional research committee (Departmental Doctoral Programme Committee) and followed by the university research committee (Advance Studies and Review Board) as academic requirement for the duration of 2013-2020. Written consent was also taken from the individual to publish the results of the case. Twenty-eight CBT sessions of one-hour duration were conducted, over a period of six months. Management plan mainly comprised decision-making techniques, cognitive restructuring, behavioural experiments, problem solving and social skills training. The individual was assessed on pre, mid, post and follow up levels. Assessment showed significant decrease in the symptoms. The present case report will help clinicians dealing with individuals with compulsive hoarding and its associated features, effectively with CBT.

Keywords: Compulsive Hoarding, Cognitive Behaviour Therapy (CBT).

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Introduction

According to DSM-5, compulsive hoarding (CH) is a psychological disorder.¹ It is described as persistent acquiring and failure to discard saved items and cluttering.¹ Vulnerability factors of CH are problems in information processing system (attention difficulties, lack of ability to categorise and organise material, indecisiveness), hoarding-related beliefs and avoidance behaviour.² Trauma, indecisiveness, perfectionism, anxiety, sensitivity and impulsivity have also been

identified as contributing factors for CH.¹⁻³ Eighty to 90% of the individuals with hoarding disorder exhibit collecting and accumulating behaviour.¹ A few studies have been conducted in Singapore on compulsive hoarding which reported 2% life-time hoarding behaviours, while 22.6% hoarding behaviour was reported in individuals with OCD.⁴ In an Indian study, 10% of the participants were identified with hoarding symptoms in a sample of individuals with OCD. Moreover, they did not try to treat hoarding-related behaviours.⁵ Literature suggests that CH is a serious psychiatric problem which significantly disrupts an individual's psychosocial life.^{6,7} Compulsive hoarding is a challenging problem as the affected individual often lacks insight regarding the condition.⁶ That is why, hoarding behaviour is difficult to treat due to a lack or absence of insight. Currently, hoarding is being treated through cognitive behavioural therapy (CBT) all over the world but very few studies are available regarding the management of hoarding disorder. Lack of insight, difficulty in decision-making, disorganisation and challenging the cognitions are the main challenges during CBT.⁸ In Pakistani collectivistic, generous and hospitable society, majority of the population belongs to the middle class who acquire items to exchange gifts, for dowry and to pass on these item to the next generation. In some cases, most of the available space is occupied, and this leads to strained relationships, poor hygiene, lack of confidence, anger outbursts and reduced socialisation, etc. In Pakistan, as in many countries, compulsive hoarding needs to be addressed but has not been reported and documented yet in psychiatric settings. Moreover, it has not gained professional attention, specifically with regards to therapeutic intervention. It is, however, treated as a sub-symptom of OCD. The aim of the current case study was to draw a line between clinical and non-clinical hoarding in Pakistan as well as to examine the effectiveness of CBT for compulsive hoarding in Pakistani setting. This case study may be considered the first clinically diagnosed case of compulsive hoarding. The aim of the current case study was to reduce the frequency and intensity of hoarding behaviours through cognitive behaviour therapy.

Case Description

A 35-year-old married man, who was working as a government servant and earning approximately

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Rs45,000/- per month, presented with complaints of hoarding behaviour, indecisiveness, sleep disturbance, anger outbursts, low confidence and interpersonal conflicts. His complaints dated back to his childhood when he perceived himself as being emotionally and physically abused by his family in routine matters. Gradually, he started acquiring and saving different items (stationary, empty bottles and boxes), living alone, feeling anger and felt satisfaction in doing so. He had a road accident when he was 18 years old; he suffered foot injury and had CT scan done. After this accident, he faced much criticism and lack of social support from his family. He attributes the onset of his problem to his family's neglectful behaviour. He reported frequent quarrels with his wife when she cleaned the cupboards and home where his material is stored, consequently experiencing disturbed occupational and routine life. He also admitted that his behaviour had led him to invite fewer friends and avoid company, because he thought that people would demand any of the items or misinterpret his behaviour as mad. He reported that his room, sitting area, kitchen and majority of the cupboards in the house were cluttered with empty food cans and boxes, used electrical appliances (juicers, irons, food cutters, choppers, shavers, grinder, etc.), stationary items (papers, gum stick, poster paints, erasers, pencils etc.), paper bags, leaflets, mobile phone boxes, old toys, old digests, expired calendars, and key rings. Due to little space, he felt distressed and even unable to move freely, consequently experiencing irritability and sleep disturbance. He reported that his problem worsened in his early adolescence and sustained with passing time. No family history of CH was reported; however, his father had been diagnosed with bipolar disorder. The patient presented with features of impulsivity, indecisiveness and avoidant personality. Moreover, he reported that he tried to avoid working with people who he believed would criticise him; he avoided meeting new people and experienced difficulty in initiation of communication. He was prescribed medicine but was afraid of taking them. So, his psychiatrist referred him to a clinical psychologist whom he consulted for two sessions at her private clinic and then discontinued due to indecisiveness about taking treatment. Because of his increased problems he was referred to the Centre for Clinical Psychology, PU, by his relatives for management.

Procedure: This study was approved by academic authorities. The patient was treated at the Centre for Clinical Psychology, University of the Punjab, Lahore, from May-October, 2018. Purposive sampling strategy was used for this single case study (N=1) with an ABABA research design.

Table-1: Treatment outcome on four levels of treatment.

Subjective Ratings of Symptoms (0-10)	Pre level	Mid level	Post level	Follow ups
Acquiring	10	7	4	0
Difficulty with discarding	10	8	5	0
Cluttering	8	6	4	0
Indecisiveness	10	7	4	1
Lack of problem solving skills	10	8	2	1
Anger outbursts	9	7	3	2
Low confidence	10	7	5	1
Lack of socialisation	9	7	4	1
Sleep disturbance	10	7	5	0
Disturbed Interpersonal relationships	9	7	5	1
Assessment Measures				
Hoarding Rating Scale	23	17	12	6
Obsessive Compulsive inventory-Revised	17	12	7	3
Saving Inventory-Revised	115	63	30	9
Saving Cognition Inventory	90	73	40	9
DASS				
Depression	14	10	7	1
Anxiety	15	13	6	3
Stress	15	12	7	3
Activities of Daily Living for Hoarding	3.3	2.1	1.3	0

Informal assessment was done through clinical interview, behavioural observation, subjective rating of problems and thought-related chart. Home visit was not possible, therefore, pictures of cluttered areas (cupboards, draws, bed room, sitting area and corridor) at home were acquired that helped in objective assessment for clutter. Formal assessment was done through standardised tests such as hoarding rating scale-interview,⁹ obsessive compulsive inventory-revised,¹⁰ saving inventory revised,¹¹ saving cognitions inventory,³ depression, anxiety and stress scale,² activities of daily living for hoarding.¹²

Case Conceptualisation¹³ (Figure-1)

Intervention:¹³ Twenty-eight one-hour, audiotaped sessions were conducted. The individual was educated for rules of intervention and connection of thoughts and emotions. Problem-solving skills, cognitive techniques, and exposure techniques were applied for managing disorganisation and lack of ability to categorise.

For acquisition: hierarchy of acquiring situations, alternative activities, cost-benefit for acquiring and exposure for non-acquiring situations were applied.

For discarding: decision-making techniques, cognitive restructuring, imagined and live discarding coping strategies were applied (15 sessions). Motivational interview, anger, interpersonal conflicts and relapse prevention were dealt side by side (five sessions). Five

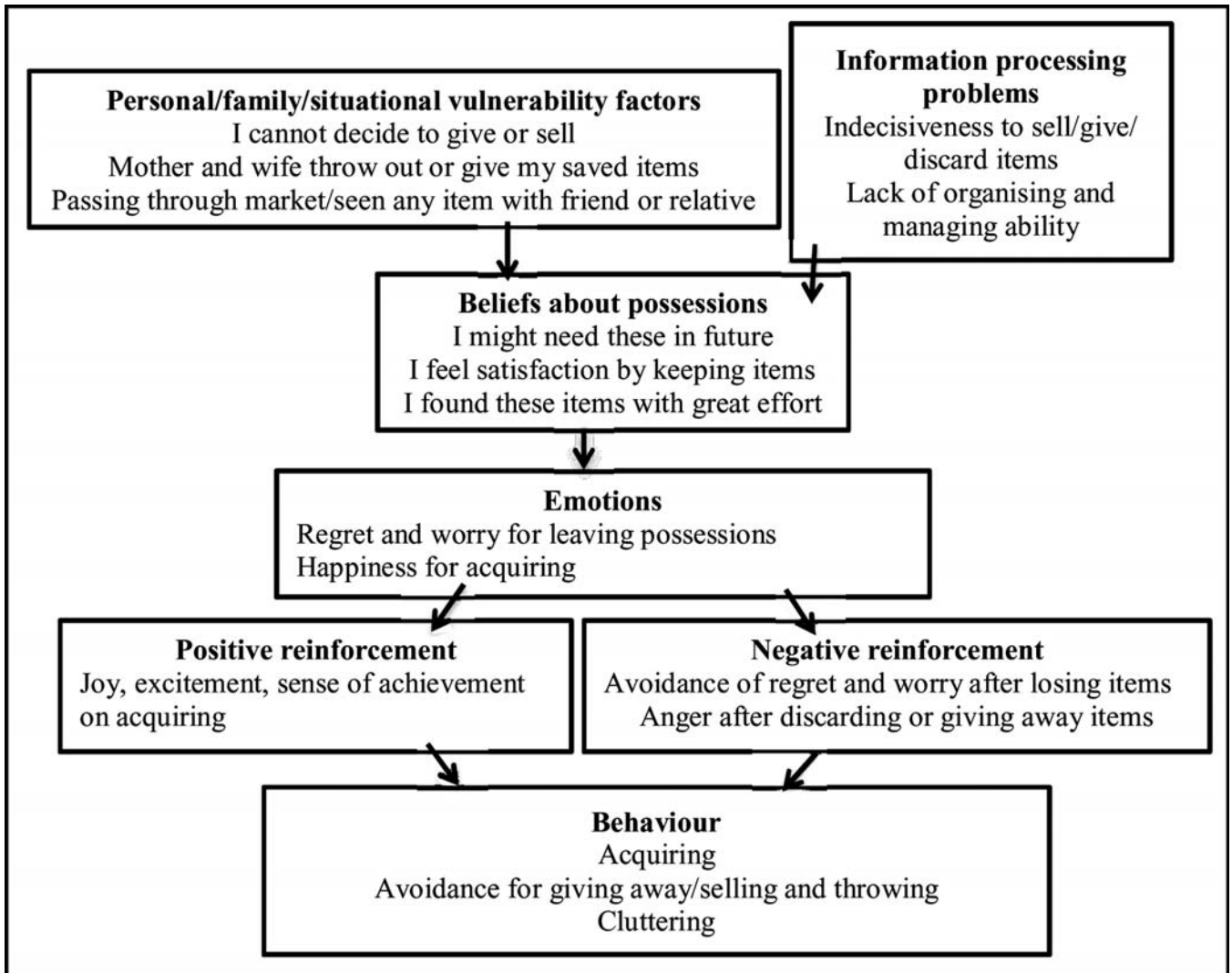


Figure-1: Case Conceptualisation.⁸

follow up sessions were conducted. Homework assignments were rated after each session on a 10-point scale. In the last session, he was provided with written material related to hoarding behaviour to prevent relapse in future. Pre, mid, post and follow up level assessments revealed drastic improvement in symptoms. All ethical considerations were followed, such as informed consent, debriefing, minimal health risks and genuine presentation of results.

Discussion/Therapeutic Outcome

In the current case, the individual presented with anxiety, depressive symptoms and interpersonal conflicts. Detailed assessment revealed CH as the root cause for the said issues. That is why, insight and motivational interviews took much time to draw a line for pathological

and normal pattern of acquiring and discarding. Existing literature also revealed that individuals with compulsive hoarding usually present with complaints of depression and anxiety.⁴ Identification and restructuring of his beliefs related to acquiring and difficulty in discarding made him realise his actual problem. His rigid beliefs did not let him leave, recycle, give up or discard any possession. His realisation of his beliefs and indecisiveness, was a major twist in the intervention and more challenging for the therapist. But till that time the individual's trust had been developed which helped in the continuation of the intervention. Previous literature suggested the same, i.e. indecisiveness and beliefs are the most significant vulnerability factors for CH.¹ While examining this case, the maintaining factors of hoarding were equally cognitive as well as behavioural and thus should have

been the focus of the sessions. That is why more time was spent on cognitive work as well as behavioural task. Cognitions are the key factors to be treated in order to resolve behavioural issues.³ Considering this case as a typical case of CH, CBT turned out to be an effective and powerful treatment.

Limitations and Recommendations

Home visit was suggested according to the standardised therapy plan but was not possible because of security reasons and cultural restrictions. Hence, the study solely relied on the individual's reporting. Little adherence was observed for homework assignment by the individual and that is why few homework assignments were completed during the sessions. An in-depth quantitative as well as qualitative study needs to be conducted on larger samples to cover the cultural aspects of the disorder that prove to be hurdles in reporting and treatment of CH.

Conclusion and Implication

CBT was identified as an effective treatment plan for CH which is currently lacking insight in Pakistani society. This case study would be considered a milestone in Pakistan for understanding, reporting and treating CH to protect society from its devastating impacts.

Disclaimer: This case study is a part of PhD project and it has not been published or presented in any journal or conference.

Conflict of Interest: None to declare.

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